Revised Draft for Discussion

To: Mr. Donald F. Capelle
Secretary, MOHE

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Re: Turning Adversity to Strength

(Note to the reader: Please read this draft with the understanding that it was written rapidly and is a draft for discussion. Errors of commission and omission are inadvertent but likely.)

I - Overview

The Republic of the Marshall Islands (RMI) and the Ministry of Health and Environment (MOHE) are entering a revenue crisis. Government funds for the operation of essential health services are already contracting. They will contract more.

The Policy Advisory Team projects a 46% decrease in government revenue over the next five years. What does this mean for the MOHE? If today were 2001, the MOHE would have to provide all preventive and curative services, at 1996 prices, in country and referral, for approximately $9,310,000 This is an expenditure cut of $2,340,000. In per capita terms it means moving from approximately $200/person/year to about $165/person/year. The latter amount is still very sufficient to provide a good service if the organizational structures and management systems are sufficient.

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Fortunately, 2001 is not tomorrow. The needed cuts, organizational changes and, in some areas, even revenue enhancement can be phased in over the next 4 to 5 years. If done expeditiously, comprehensively and with care, there is enough money to provide all Marshallese citizens with a full range of good quality primary and secondary care services and selected tertiary and referral care.

Although the full impact of the government revenue contracture will not be felt for 4 or 5 years, action to minimize the impact cannot wait. Some personnel reductions have already been implemented, the maintenance budget is zero for Majuro Hospital, the drug and medical supply budget has been substantially reduced from last year and it is highly likely drug funds will disappear without warning sometime after the half-way point is reached this fiscal year. An unmaintained hospital, without drugs and supplies is no more than a deteriorating building and empty promise to the people. This will also mean primary care deteriorates as basic hospital services are essential for primary care to succeed.

As Secretary Capelle has stated the ADB health project is intended to have a radical impact on the MOHE. Nothing short of radical change will suffice to stop the down hill slide in health services, reverse direction and move to a leaner but more effective, vigorous and strong RMI health program.

This memo will outline the underlying causes for today's acute and growing problems in financing and managing RMI health services. It will then suggest specific steps for correction, including a design-to-revenue approach to budget and program planning. Hospital bed need for the next 5 years will considered and a revised, streamlined, organizational structure for the MOHE and Majuro Hospital will be suggested. Underlying most of the specific, suggested approaches are three broad themes:

- Organizational Change and Political Will
- Expenditure Control
- Revenue Enhancement

Organizational, financial and personnel management changes within the MOHE are necessary. However, no amount of change within the

MOHE will be sufficient to stop deterioration and reverse direction. It is essential than the nation' political leaders support:

- Changes in the management of the Health Care Fund
- Changes in the management of referrals
- Change in the Public Service Commission authority with regard to the MOHE
- Changed attitudes that reinforce confidence in Majuro Hospital and recognize that overseas referrals can and must be very limited.

<u>One step should be taken immediately</u>

- Commingling of drug and supply funds with referral monies should stop now. 75% of Health fund payroll tax revenues should go exclusively to the drug escrow account until the minimum needed funds for the year have accumulated. This figure is between $600,000 and $650,000 for Majuro Hospital and a lesser, to be determined, amount for Ebeye Hospital. Total essential drugs and supply funds for the entire MOHE for this fiscal year probably fall between $850,000 and $1,000,000. <u>If commingling continues, the RMI can expect severe, unpredictable shortages of essential drugs and supplies with needless death and suffering</u>. Expenditures from the escrow account must require the signature of the Secretary MOHE or his designee. The reasons for this are explained in more detail in a later section of this memo.

The approaches suggested in this memo are difficult. Some people will loose their jobs, others will loose authority. Virtually everyone will have to work harder and produce more. Attitudes that underlie many practices will have to change. However, planned change will be more humane for the individuals affected and will result in a better and stronger MOHE rather than reactive change. Delay in implementing essential changes could mortally wound the MOHE, particularly its clinical services.

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II - The Major Problems

Items 1 to 4 immediately below have a profoundly adverse effect on the MOHE. However, their solution is largely outside the control of the MOHE and will take action and sustained political will from the nation's political leadership.

Item 5 speaks to various management issues largely within the MOHE, and largely under MOHE control. However, it is essential to stress that addressing issues that are just internal to the MOHE without simultaneously or, even better, first addressing the external issues will be nothing but a waste of time.

1 - Referrals are out of control. Drugs and essential supplies are in jeopardy

- All statutory controls on referrals are reported to have been have been removed by the Nitijela.
- The physicians at Majuro and Ebeye are effectively powerless to stop referrals in the basic referral program supported by the health tax ($10 bi-weekly payroll tax) because of political pressure and perceived threats to their continuing employment.
- The supplementary insurance program ($15 bi-weekly payroll deduction) also has no effective entry controls. It offers a $100,000 medical benefit with housing and per diem in addition if the beneficiary can pay airfare and a $100 deductible. The premium structure appears unrelated to the benefit package. MOHE physician control of this program is irrelevant as it is perceived and administered as an entitlement program.
- Once a person is referred there is no effective way to assure care is medically needed or to end their financial support.
- Referrals have priority over drugs and supplies.
- This resulted in a severe shortfall in the Health Care Fund last year. Even though the proceeds from the 1% increase in the social security tax were credited to the health fund, the fund still ran out of money two or more months before the end of

the fiscal year. Queens Health Plan in Hawaii is reported to have canceled its third party administration contract for non-payment. Drug and supply purchases were either delayed or not paid for. It is reported that a final overage from the last fiscal year is on the order of $2,000,000. Unpaid drug bills may be in addition to this figure.

- Some suppliers will no longer do business with the RMI unless they are paid in advance or funds are put in escrow. Some suppliers with unpaid bills will not ship new products until their old bills are paid.

- Last years debts will come out of this years health care fund revenue. If debts and referrals are paid first, the funds available for drugs and supplies this year are likely to be trivial.

- If drugs and supplies stock-out, the pressure and need for referrals will increase.

- This amounts to a fiscal hemorrhage that could be lethal for the MOHE.

What to do

A - Stop commingling Drug and referral funds now. Place drug funds in an escrow account on an 75% of health care payroll tax revenue received basis until the minimum funds needed for the fiscal year have accumulated in the escrow account. MOHE to have control over all disbursements from the drug escrow account (see above).

B - Radically change the management of the Health Care fund and referral practices (see section V below)

2 - Maintenance funds for Majuro hospital have been reduced to $0.00

Zero funds by any standard are grossly insufficient for maintenance. The maintenance at Majuro hospital is already precarious at best. It is impossible to run a hospital or other health facility without, in the case of hospitals, substantial, recurring maintenance expenditures. This is true for Majuro and Ebeye and, to a lesser

extent, for all dispensaries. The annual hospital recurrent budget should have no less than 4% allocated for maintenance. At this time the hospitals have several types of maintenance needs:

Deferred maintenance
Preventive maintenance
Unexpected repairs

What to do

A - A plan should be developed for meeting the deferred maintenance needs over a three year period.

B - A preventive maintenance program for the building and equipment, medical and non-medical, should be developed, funded and implemented.

C - Funds must also be set aside for unexpected repairs.

D - The total maintenance budget should be no less than 4% of recurrent annual hospital expenditures for Majuro and Ebeye. The dispensary figure can be lower.

3 - The Public Service Commission Stands in the Way of Effective Personnel Management at the MOHE

Timely hiring of qualified persons, disciplining personnel short of firing and firing for cause are effectively not possible working with or through the PSC. The MOHE cannot wait for reform within the PSC. It needs to be able to manage its own personnel. This is a widely recognized, well documented problem. Tardiness, absenteeism, abuse of vacation and sick leave have the net effect of decreasing the productivity and efficiency of the entire MOHE while also undermining morale of those people who are trying to do a good job.

What to do

A - Transfer the authority for hiring, disciplining (up to and including suspending without pay for periods ranging from a day to a month) and firing from the PSC to the MOHE.

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B - Establish a position of Director of Human Resources consistent with the new authority and responsibility given to the MOHE for personnel management. This is a full-time position senior to the current position of Director of Personnel. This new post will require a sensitive but tough and dedicated person with substantial inter-personal skills and a good knowledge of personnel management. Patronage and favoritism must be severely curtailed and hopefully eliminated.

C - Establish personnel policies that require persons to show up for work on time, prevent abuse of sick and vacation leave, and establish criteria for discipline and termination. (See Huddart report of August 16, 1996).

D - Establish new or revised job descriptions which clearly state overall duties and responsibilities, specify a single supervisor, list illustrative tasks, always include a phrase stating "such other duties and responsibilities as may from time to time be required." Job descriptions are to cover every position form Secretary to entry level service and clerical personnel. If a person is expected to travel within the RMI and/or overseas this expectation is to be clearly specified, including an upper limit on the time senior and mid-level managers can be overseas.

E - Assure that Senior managers in the MOHE and hospital lead by example. In case they do not, they must suffer the same or greater penalties as a lower level worker.

F - Once A is accomplished, request technical assistance in carrying out items B through F above. This will be a natural extension of the work already done by Jenny Huddart. However, this work should only begin after the MOHE has settled on a new organizational structure (see 5 below). Which TA vehicle should support this activity merits discussion. The result of this should be reallocation and reassignment of some personnel as well as further reductions in overall numbers of personnel.

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4 - Elected Officials Often Do Not reinforce the Strengths of the Hospital

Understandably but unfortunately, the members of the Nitijela often find it desirable to criticize care and practices at the MOHE hospitals and also encourage constituents to travel overseas for medical care. This has the effect of undermining the public's confidence in the hospital and hurting the morale of the staff.

The RMI simply cannot afford to send citizens overseas at the rates which have become common and expected. Patients will have to get almost all of their care within the RMI. This means the Nitijela needs to be supportive of the MOHE in terms of its budgetary needs and when it comes to educating the public to the benefits of hospitalization within the country.

What to do

A - The MOHE, with the support of the nation's political leadership, should undertake a process of health policy education for key members, possibly all members, of the Nitijela. The intent of these one-on-one and small group discussions would be for the MOHE to learn in a non-adversarial, private forum of the real concerns of the members and for the members to gain a better understanding of the strengths and weaknesses of the MOHE, particularly the hospital services, so that they can provide better and more informed support through the legislative process and by helping to change consumer attitudes and expectations.

B - The media should be given a special welcome and be briefed on MOHE activities and programs with a view toward generating news coverage that builds the public image of the hospital. When there are problems, the media should be advised by fully informed senior managers in the MOHE before the problems are discovered by the media and perhaps presented in a less favorable light.

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5 - The MOHE Organizational Structure is cumbersome and breeds inefficiency. Planning and management systems and related human resources are not sufficient to support MOHE operational needs.

The MOHE is a complex organization dominated by one central hospital that is also complex. An organization with service and personnel scattered over many islands and hundreds of miles of ocean that s facing serious revenue reductions and whose clients have changing and growing needs requires a cadre of skilled senior managers. At present there are insufficient experienced senior managers in the MOHE. For a population of nearly 60,000 people, 3 to 4 health care managers trained to the masters degree level in health administration, hospital administration, public administration or business administration would be a reasonable goal.

The RMI government and the MOHE suffer from a shortage of trained, experienced and effective managers. This management resource needs to be urgently augmented in the short-term, with training and development set in place for the long-term. In addition, as there are so few managers and management time is as precious a commodity as money, it is imperative that the organizational structure within which managers work facilitates rather than hinders the work of good management. The external forces in MISSA, the PSC and the MOF and the outdated and rigid internal structure of the MOHE could break the will of the most dedicated manager. Although somewhat intangible, this is a powerful reason in support of the changes this memo recommends for organizational changes external and internal to the MOHE. If a mangers time is wasted and there are few managers, many opportunities are lost.

Up to the present, there has not been a great need to have internal financial planning and cost finding systems in place as financial management was largely fragmented and external to the ministry. Controls are imposed from either MISSA or the MOF. Revenues, in the sense of budgeted amounts of government funds, vary with little notice from outside the Ministry. Within the MOHE there is only one person who is actively and regularly involved in the tracking of invoices and some expenditures. There is no way to regularly and routinely relate expenditures to revenues or to major program elements. Service outputs and measures of activity are poorly defined and reporting is inconsistent and not related to management needs. The identification of costs and unit costs is not currently possible and the financial information that managers need for

guiding an active organization facing substantial financial threats is lacking. Integrated financial and program planning and the prudent forecasting of needs is simply not possible with current MOHE systems.

The organizational structure of the MOHE and Majuro Hospital is not relevant to today's or tomorrow's needs. There are too many organizational units with overlapping and unclear responsibility. This leads to duplication, inefficiency, confusion and waste. It also serves to support a false justification for the jobs of some managers responsible for units which should be abolished and/or combined with other units.

What to do

A - Decide on a new organization structure for the MOHE. A suggested structure based on the observations and analysis of the Queensland University of Technology (QUT) and Boston teams is illustrated and discussed in section VI below.

B - Complete the Health Management Information System. This is on schedule and should be substantially compete this Fall under the Boston University TA.

C - Revise and complete the 5 year rolling plan, the detailed one year plan and the planning manual for the MOHE using this memo, after discussion and revision, as the broad framework for shaping the manual and the plans.

D - Use the new, design-to-revenue, plan and planning process as the basis for next years MOHE budget submission. This process is more expansive than originally envisaged and may require additional resources beyond those currently available in the Boston TA. The plan will include and directly address the implementation of the organizational changes needed outside the MOHE as well as within the MOHE. A draft, still very much a skeleton, model that suggests the approach to be taken in designing to revenue is presented and briefly discussed in section VII below.

E - Develop, in a manner that is seamlessly integrated with the program-budget planning process, financial systems and

procedures sufficient to allow the ministry to prudently manage its resources, identify costs, quantify and allocate revenues and expenditures and accurately project needs. We suggest that Mr. Feeley take responsibility for providing overall guidance for the design and implementation of the entire financial and program planning and budgeting system. He will undertake much of the work, particularly at the more macro level, himself. With assistance from a person skilled in accounting systems, he will assure that the accounting systems are well implemented and appropriate to MOHE and RMI needs.

Queensland University of Technology (QUT) and Boston are in agreement that much of Mr. Feeley's proposed work fits within the intent of their activities and both institutions are committed to working out the administrative arrangements to facilitate this.

F - Structure the overall planning and health management information system process in a way that contributes to the production of a timely and relevant MOHE Annual Report. A draft annual report format dated October 16, 1996 has been approved in principle by Secretary Capelle and is incorporated by reference into this report.

III - Revenue Enhancement

Are there areas where revenue could be increased? This can come about in several different ways.

1 - Seek ways to take fuller advantage of the Kwajalein Resource

There are good but informal arrangements with the contract Hospital on the Base at Kwajalein. As this hospital is very well equipped, well staffed and well maintained and able to provide services to a far larger population than is in residence at the Base, there may be options for increasing the benefit of this resource to the RMI at little or no cost to the US Government or the Government of the RMI.

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What to do

A - Suggestions along the lines outlined above have been provided to the MOHE (Appendix 1).

2 - Increase US Federal Health Grants.

It is likely that the full potential in terms of revenue and program support from US federal grants has not been reached. The process of finding, announcing and applying for grants is complex. The federal grant and contract process was, at a minimum, not designed with constituencies like the Marshall Islands in mind. States and cities are the intended beneficiaries and the expertise to successfully mine the federal coffers lies with those who do it on a regular and intensive basis. The grant writer for the city of Boston is known to me and she has successfully written tens of millions of dollars worth of grants over the past 5 or 6 years that otherwise would have been lost to Boston. I strongly suspect the same could be true for the Marshall Islands.

What to Do

The Center for International Health at Boston University, now has or can easily acquire most of the information needed to apply for federal grants. I suggest that the Boston TA be expanded to include:

A - Survey Federal Grants applicable to the Marshall Islands:

- Are existing grants structured to your maximum advantage?
- What is the magnitude and type of other grants and to what extent are they applicable or can be made applicable to the Marshall Islands?

B - Write the grants in Boston with review, approval and signature remaining with the Secretary or his designee.

D - Seek to structure the administrative and program content of grants in such a way that after one or two years the cost of grant writing is covered by the grants themselves.

E - Develop a strategy for managing and integrating the grants into the overall program structure of the MOHE without either distorting the organization or organizing to meet federal guidelines.

F - Explore low cost, flexible administrative strategies for grant management similar to those used by many US state and local governments to manage federal grants.

3 - Selectively Increase User Fees

Now revenues from user fees are minimal, around $100,000, and the cost of collection approaches half the value of the revenue. Certainly at the income levels in the Marshall Islands the potential for greater revenue generation is present. As well, when people pay for a service, they often value it more. More user fees could not only contribute financially but they could help in improving the public's image and perceptions of curative services. However, user fees are not a revenue panacea or cure-all. They must be applied with care so that needed services are not denied and generally they should not be applied to proven preventive services (e.g. immunizations, pre-natal care, well-child-visits, screening for hypertension and diabetes). User fees also have to be set with a knowledge of what are the true costs of a particular service and with some understanding of and sensitivity to the economic plight of the population, particularly those who are not well off. When fees are collected, it is important they remain in whole or substantial part with the organization that collects the fee. If increased user fees automatically mean a lower government budget, there is little incentive to collect user fees.

There is an upper limit to what user fees can contribute to overall revenues. It is a fair generalization to state that all hospitals of any meaningful size, that actually serve the poor as well as middle and upper income persons, always require substantial government subsidy. 20% to 25% of costs is probably the upper limit that user fees can cover and in the RMI it is probably much closer to 10% of curative expenditures. The bulk of user fees will be generated by hospital-based services and that is the place to start.

What to Do

1 - Within the framework of the financial management technical assistance, identify the unit costs of services.

2 -Perform a feasibility study that addresses the potential for user fees in the following settings:

- Majuro and Ebeye in-patient services
- curative urban ambulatory services
- curative Outer Island Services

This plan should estimate the revenues associated with different fee structures and levels, costs of collections, distribution and use of receipts and the pros and cons of various approaches.

3 - After review and if approved by government, introduce increased user fees.

It is essential to remember that user fees work when services are good and are perceived to be of real value. It is generally a flawed strategy for governments to try and generate user fees from substandard services in the hope of later improving the service. Thus, it may not be feasible to implement user fees for some curative Outer Island services until the quality of the overall Outer Island Service is improved. This is equally true for hospital-based services.

IV - New Hospitals: Opportunity or Threat?

As will become clear, new hospitals that replace older hospitals, in this writer's experience, virtually always have higher operating costs. Not only do the recurrent costs of a new hospital typically exceed the recurrent cost of the hospital that is being replaced,. The recurrent costs are also usually higher than predicted by the planners and designers. I first consider the issues around new construction and recurrent costs, then whether or not there is a need to replace the existing hospital on the grounds of either poor physical condition or a need for more beds. Finally an approach to

developing and analyzing four options for improving the physical plant of the hospital are outlined. They range from doing just deferred maintenance to a complete new hospital. The objective is to determine what is the best way to affordably meet the needs of the RMI for improving the Majuro Hospital physical plant.

1 - Recurrent Costs

New hospitals invariably, and I say this advisedly, have recurrent costs higher than anticipated. In the US, the method we used in Massachusetts to estimate the recurrent costs of new hospitals was that recurrent costs equal the capital costs every 18 months. Put another way, every year the recurrent costs will be 66% of the capital costs. The ADB proposes a lower figure of 40% as the planning guideline for the Marshall Islands . Either figure will have daunting implications for the RMI. A 12,000,000 dollar hospital if completely constructed and equipped with donor grant funds with no loan pay-back will require between $4,800,000 and $7,920,000 to operate each year. These funds must come from RMI revenues.

Note that the current budget for Majuro Hospital including drugs appears to be no more than $3,000,000 (this figure needs to be verified). The additional money required to operate a new hospital would range between $1,800,000 and $4,920,000. This is simply not affordable in the current or projected financial environment.

2 - The RMI Need for Beds

Is there need for a new hospital? If the current hospital is in sufficiently bad condition, replacement could be warranted. Or, if there is a shortage of beds replacement could be justified. Let's examine both possibilities.

Is the existing hospital in such poor condition that the costs of deferred maintenance and the complexities of bringing the hospital up to a reasonable condition require replacement rather than repair? The answer is clearly no. A careful assessment of the maintenance needs of the Majuro Hospital has just been completed under the QUT TA and the conclusion of the engineer was that only minor to moderate work was required and the hospital had many years of

useful life left (Repair and Maintenance Manual and Report, September 1996, Ken Cochran PE)

Are more beds needed to meet the needs of the population?

I have calculated bed need using generous assumptions for hospitalization. For example, all admission rates for all age groups are raised 10% above US HMO norms. For 15 - 44 year old females, admissions are raised by 30%. Lengths of stay are also generous. The calculations are shown in Appendix 2.

The result is 76 acute general hospital beds needed for the nation as a whole. Majuro currently has somewhat in excess of this number. Ebeye beds bust also be considered and a certain number of patients are cared for at Kwajalein or sent overseas.

Beds in Service:

Majuro = 86
Ebeye = 25 (although the hospital can house 35+ patients)
Kwajalein* = 2
Overseas** = 6

Total = 119
Need = 76

Surplus = 43

* Assumes the total in-patient use of Kwajalein averages to two beds.

** Assumes referrals are 10% of the patient days required at 100% occupancy. This translates into 6 beds

The current supply, if well managed and maintained, appears more than adequate now and, particularly given the excess supply, will certainly remain adequate at least through 2001.

What if by some chance, more beds are needed later in the next decade? It would be far more prudent to build a small additional wing, perhaps for private patients, onto the current hospital and use existing core hospital services to support such a small new wing.

There is no need now or in the foreseeable future for a new hospital with additional beds in Majuro. Were a replacement hospital to be

built, there is every likelihood that its operating cost requirements would exceed the nations ability to fund these costs. However, it is reasonable to ask what are the options for improving the current facility and what is possible with regard to physical improvement within the recurrent budget available. And, particularly as donors are often available to fund construction of new hospitals, but not their recurrent costs, it may be prudent to determine unequivocally either 1) a replacement hospital of the requisite size would be unaffordable or 2) with careful and clear specifications, an affordable new donor funded hospital could be built.

What to do

A - Defer any decision to build a new hospital and simultaneously

B - Engage a consultant or small consultant team. The skills required are architectural, recurrent cost analysis and health planning (Ms. Monserud and Mr. Feeley would be appropriate choices. An engineer with good knowledge of hospital equipment may also be needed. Ms. Monserud is described in more detail just below in the Ebeye Hospital discussion). The tasks are to 1)carry out a feasibility study to assess the four options outlined below and 2) make a specific recommendation to government on how to proceed with regard to repair and/or renovation and/or replacement that is realistically predicted to be affordable within the current levels of recurrent expenditure for hospital operations.

The charge to the consultant is to determine the costs and benefits of each of the following four options, rank the options in preferred order and make a clear and specific recommendation as to which option(s) are preferred and why.

The space being studied is the entire space now occupied by the MOHE including the hospital, public health space and administrative support areas. Specifically, the entire footprint of the buildings behind the main government offices that house the MOHE.

All options are to be structured so that after they are completed the operating costs of the hospital are projected to be the same or less than the present recurrent budget now available to the MOHE to operate the hospital. If, in any option, it is not possible to do this, the overage must be precisely quantified and explained.

- Option 1 - Carry out all needed deferred maintenance to bring the hospital back to full function from a physical facility perspective. The consultant is to consider the physical plant and major or essential, medical and non-medical equipment, equipment. Repair costs are to be specified and the impact, positive, negative or neutral on recurrent costs estimated. This option is to be contrasted in terms of strengths and weaknesses with the other three options.

- Option 2 - Option 1 plus minor renovations to improve overall operating efficiency, patient flow, infection control and the like.

- Option 3 - Option 1 plus moderate renovations which may add to option 2 or replace 2. This option could include modest additions of space if that were judged to be of overall operational benefit.

- Option 4 - Option 4 a new hospital deigned to operate within the 1996 recurrent budget actually available to the hospital this fiscal year. (If the hospital were opened today it could operate well and sustain itself including needed ongoing maintenance with the framework of this year Majuro Hospital budget. Size to be determined by a bed planning exercise and the scope of services to include a full range of secondary care and limited tertiary care. This option should be framed so that if it is doable it can serve as a design specification to be followed by the donors architect, engineers, construction supervisor and contractors. If this option is feasible, the donor documents should contain language that provides financial guarantees to the RMI if the recurrent costs during the first five years of operation, adjusted appropriately for inflation, exceed 8the design specifications.

3 - A note on the new Ebeye Hospital

This hospital is partially complete. It has serious design and construction flaws. In addition, the design does not relate well to the health care needs of the population. As currently planned the

hospital will have a recurrent cost impact that will be very difficult for government to support and will certainly far exceed the present recurrent costs at the existing Ebeye Hospital.

What to do

A - The new hospital should be completed.

B - Before it is completed it should be carefully reviewed by a hospital architect with developing country experience who can suggest changes to be made before the hospital opens that will substantially improve functionality and decrease operating costs. This will only take a few weeks to carry out. The cost for review will be modest and the benefits in terms of better function, careful planning and specification of costs to finish the current building and operating cost control will be significant.

I recommend Ms. Susan Monserud for this task. She has extensive developing and US hospital and clinic architectural design experience. Ms. Monserud also has substantial health planning skills and understands designing to meet recurrent cost targets. She can be reached through Boston or directly by phone at 203-266-4800, by fax at 203-266-4848 or by Email at SMonserud@aol.com.

C - The program for the hospital should reflect the medical care reality of Ebeye. Very little major surgery is done in Ebeye. The reason is simple. Not enough people live there to generate the demand needed to support an in-patient surgical service. Ebeye currently has a robust clinic program, a busy labor and delivery service, and a small number of persons with social conditions who are housed in the hospital for non-medical reasons.

The new Ebeye Hospital should be reviewed with an eye toward running it as a dynamic ambulatory program ,with a busy delivery service. Other in-patient services should be limited to straight-forward medical and pediatric cases with surgery limited to minor surgery and the occasional emergency Cesarean section. This becomes an affordable relevant hospital and health care program that will meet the

populations needs for the next decade. In fact, this almost exactly describes what currently takes place at Ebeye. The new hospital and its program of services should reflect this reality.

D - Plan the new Ebeye Hospital program to operate within a specified, affordable recurrent budget. Any architect or planner who is engaged should be instructed to plan the facility and programs such that they can operate within a specified overall recurrent expenditure figure. More analysis of the MOHE budget is required before a final recurrent expenditure target in current dollars for Ebeye can be given with confidence. However, it would be imprudent at this time to assume more than the current level of recurrent expenditure.

V - Managing the Health Care Tax Funds

1- Managing Referrals

The problem has already been presented in the opening part of this memo.

What to Do

Excellent medical care is available in Manila at prices well below US prices. Even at lower prices, it is very unlikely that the RMI government will be able to afford to pay for everyone who needs or wants an overseas referral. More and more, health care for the Marshallese will have to be provided within the geographic confines of the Republic. This means the hospital resources of the country, particularly Majuro Hospital, need to be strengthened. The question is how to do this at a time when financial resources are contracting.

A - Change the program approach from referral to integrated tertiary services. Emphasize building affordable and appropriate in-country capacity, bringing visiting medical experts to the country and only use overseas care when it can be afforded and it is likely to be of significant benefit to the patient.

Occasional cardiac surgery in children might be done overseas, most cancer management would be done in the RMI with tissue diagnosis overseas, surgery here and chemotherapy treatment protocols developed in consultation with the overseas resource. Coronary by-pass surgery for people my age would be outside the envelope of government supported services.

B - After determining the amount of funds minimally needed this fiscal year for drugs and supplies, subtract that from projected health care tax revenues. If and only if the revenue stream permits after assuring funds for drug and supply purchases, place an absolute cap on referrals up to, but not more than, $1,500,000. This figure is to cover all expenditures paid by government including airfares, escort and patient per diems. As soon as a contract is negotiated with a good Pacific Rim provider, there would no longer be a need for the apartments in Hawaii as Hawaii referrals would, for all practical purposes, cease.

C - Suspend all benefits and new referrals under the supplementary insurance plan ($15 bi-weekly additional payroll deduction). Allow private insurers to offer overseas medical insurance in the RMI that is not subsidized by government. Review, the use and costs associated with the supplementary plan and if it cannot be put onto a sound actuarial footing that assures revenues plus reserves will always be sufficient to cover expenses, the plan should be terminated. An alternative, given the near certainty that the plan is unsound and cannot be made self-supporting, is to terminate the supplementary insurance plan immediately, stop collecting the additional tax, and state that the RMI now has a single integrated plan for tertiary care services.

D - Rapidly develop a comprehensive contract for Integrated tertiary services and management. Stop sending referrals paid for by government to Hawaii as soon as an alternate provider is under contract. Probably use Manila and use one or at most two hospitals there. Assuming there is interest and a favorable contract can be made, If at all possible it would be desirable to deal with only one, high quality, full-service, tertiary care, medical center such as St. Luke's. In addition to carefully selected services for patients referred to Manila, the contractor should be asked to also provide visiting

consultants to do specialized surgery and provide in-service education in the RMI and provide remote back-up diagnostic services such as the review of X-ray films and performance of tests on specimens (not just people) sent to Manila.

Escorts would be provided to Manila only if medically needed. The contract would include provision for low-cost housing for patients who were convalescent or undergoing diagnostic testing on an ambulatory basis. Needed social, translation and airport to hospital transportation services and related support services would also be included in the contract. .

Finally, and perhaps of most importance, the contractor would, within the framework and included within the price of a comprehensive, probably fixed-price, contract, recruit a very good health care manager. The manager would have three roles and 1) function as the Majuro Hospital Director with line authority for all hospital operations and 2) serve as the management adviser to the Secretary of the MOHE for the entire Ministry. This person would also 3) function as the on-site contract manager for the entire contract with the parent institution and be responsible for assuring that the relationship between the parent institution and the RMI worked.

The health manager who will have line responsibility for Majuro hospital and also serve as the senior management adviser to the MOHE could be recruited on a stand-alone basis. The key point is that this person is essential and will be a focal point for catalyzing change within the MOHE. However recruited, the health care manager, without parallel radical change in managing referrals and developing more capacity for diagnosis and treatment within the RMI, will face a near impossible task.

E - Exception to the Hawaii referral ban - If a Marshallese has 1) legal pre-paid access to US health care that in no way uses or obligates RMI funds, 2) otherwise would be referred to Manila and 3) fully meets the criteria for referral to manila, and 4) needs only airfare, then the RMI pays the airfare for the patient. Escort is paid only if medically indicated. Escort and patient per diems are limited to up to 30 days and may be less.

F - Maximize the use of Kwajalein for referral services to the extent this can be arranged.

2 - Managing Revenues from the Health Care Payroll Tax

The problem is the funds available for drugs and supplies cannot be predicted. This situation is incompatible with running a safe and effective hospital. As well, with proper management, it is likely there will be a surplus of funds in the Health Care Tax fund. This should be used for strengthening essential services and some money should be set aside as an emergency reserve.

What to Do

A - Assure Funds for Drugs and Supplies.

- Project health tax revenues for the coming year.

- Determine the minimum amount that each hospital and the Outer Island service requires for drugs and supplies Add the referral amount to this. If this is 90% or more of the total revenue projected to be available, reduce the referral funds. If there is irreconcilable conflict between the two funds, give priority to drugs. The rationale is that keeping basic in-country services operating does more good for more people than a comparable amount of money spent on referrals.

B - Establish needed new uses for health care tax revenues.

Over a period of one to two years, it is likely that referral expenditures can be substantially reduced and the health tax can be used for purposes in addition to referrals and drugs and supplies.

Therefore the Health Care Tax administrative structure should anticipate four broad uses for the revenues:

- Integrated tertiary services (referrals, on-island tertiary capacity and management)
- Drugs and supplies
- Strengthening Essential Services:
  - Health Promotion
  - Outer Islands Primary Care
  - Maintenance Services
  - Laboratory Services
- Emergency Reserve

Decayed teeth, obesity, hypertension, diabetes, and alcohol abuse all speak to lifestyle issues and the need for health promotion. Some of these conditions can be prevented and in sometimes complications can be prevented or delayed. In all cases with effective health promotion, with citizens take responsibility for adopting and supporting healthy lifestyles, the burden of preventable illness will decrease. This is a worthwhile investment.

It is clear the Outer Island service needs to be strengthened at the point of delivery. Maintenance has already been mentioned and the primacy of maintenance will show in the organizational structures suggested below. The Majuro Hospital laboratory service is in poor condition. A reliable laboratory, with fast turn-around of basic tests, with some readily available 24 hours a day is an essential hospital support service. This does not currently exist. The fundamental problem is personnel and management and there is probably also a need for augmentation of supplies and improved maintenance. With the strengthening of hospital management, reorganization of the hospital and the MOHE and the availability of some additional funds, the laboratory problem can be readily solved.

An emergency reserve is recommended as there are always unexpected but essential expenditures that come up in the course of a year.

VI - A suggested Organizational Structure

The intent of this organizational structure is as follows:

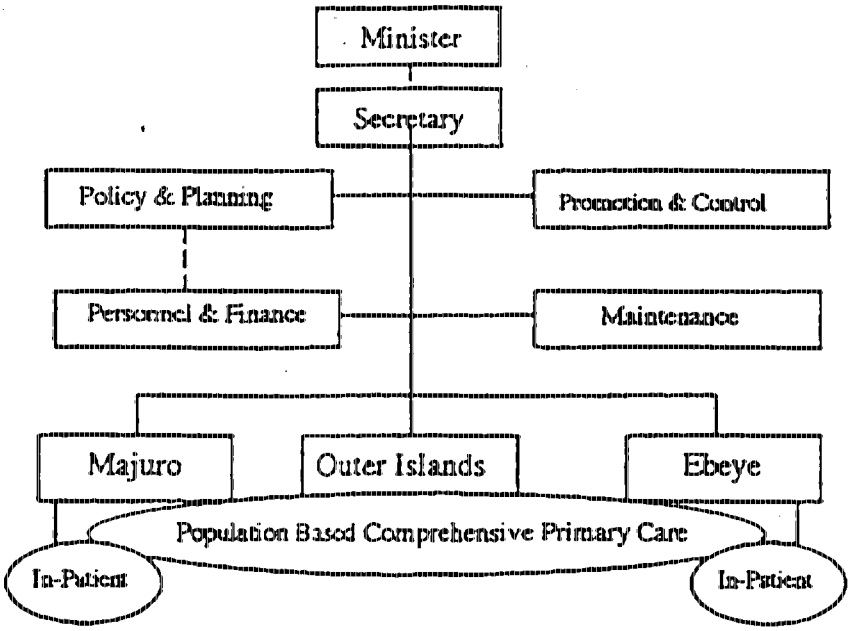
- Strengthen urban and Outer Island primary care services
- Remove duplication and decrease overlap and waste
- Simplify and clarify lines of authority and responsibility.
- Save human and financial resources

The organizational structures are shown in broad outline and are based on input from QUT and Boston team members. Once sufficient agreement, but not consensus, is reached on the broad approach to a new organizational structure the details can be filled in. After agreement on overall structure, then tasks can be analyzed and staffing needs determined. The suggested structures speak mostly to functions of a position not who should occupy the position. Once the functions are determined then one can move to determining who should fill what position and who is redundant. With a more rational and streamlined organizational structure and improved management systems, fewer people will be able to do more. For example, it will be possible to rationalize the Outer Islands structure and reassess the number of dispensaries and health assistants so that coverage is adequate but not in excess.

(Please see next page)

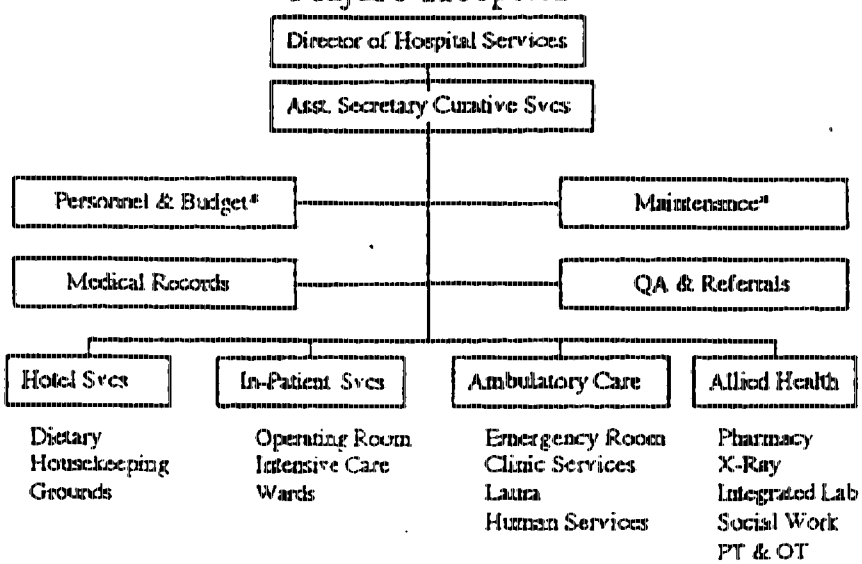
Revised Draft for Discussion

A Re-Organized MOHE



A suggested simplified structure for Majuro is shown that functionally integrates all ambulatory and in-patient health services now operating in Majuro.

Majuro Hospital



* Provided by MOHE

As Majuro Hospital is re-organized, serious consideration should be given to contracting out hotel services to the private sector.

VII - A Draft Design-to-Revenue MOHE Planning Model

This approach seeks to make the process of reducing expenditures more rational and present the consequences of alternate approaches to expenditure reduction clear to all parties. It allows for selectively strengthening some services and activities as other are down-sized or eliminated. The net result should be a stronger, leaner and more productive MOHE.

The process begins with a projection of year 2001 revenues but expressed as 1996 dollars. This is the revenue target that all expenditures must fit within. This allows current expenditures that are well known and easily understood to be used without corrections for inflation or other factors. Projections for future years will also be in current dollars.

The model will allow budget to built by program elements and the consequences of alternative budget structures seen in terms of personnel and non-personnel costs and the allocation between major programs. It will also highlight a maintenance minimum and a minimum for non-personnel costs as a percent of total costs. As the Health Management Information System begins to have outputs, planning will become richer and the ability to quantify the impact of alternative program and budget approaches on service delivery, units of service and unit costs will be more apparent.

The skeleton of such an approach is suggested on the spreadsheets in Appendix 3. This will be refined, completed and included in the planning manual and be used to quantify the expenditure and revenue impact of the annual and five-year plans.

VIII - Summary

The rather bleak RMI revenue picture presents the RMI and the MOHE with a window opportunity that will shortly close and be very difficult to open again at a later date. Preserving and enhancing affordable and sustainable health services of good quality that are equitably available to the entire population for humanitarian and

productivity reasons are the objectives underlying the approach outlined. This can be accomplished. Reorienting and coordinating existing technical assistance in close cooperation with the MOHE leadership and key players outside the MOHE can result in a stronger, more relevant and vigorous MOHE in the years ahead.

Appendices: (3)